Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: ACCESS MEDIQUIP PO BOX 421529 HOUSTON TX 77242	MFDR Tracking #: M4-07-3278-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: AMERICAN HOME ASSURANCE CO Box #: 19	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Rationale for Increased Reimbursement: "See complete description attached. Also review TX Work Comp Fee Schedule."

Principal Documentation:

1. DWC 60 Package
2. Medical Bill(s)
3. EOB(s)
4. Medical Records
5. Total Amount Sought - $437.73

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "The Requestor in this matter requests an additional $437.73 for equipment that is used with an implanted stimulator. The Requestor contends that they are owed additional reimbursement due to the Texas Workers' Compensation fee schedule. Respondent contends that they were paid accurately according to the fee schedule. Please see the attached EOB which allows a reimbursable of $1,081.45 for CPT code L8681." "Therefore, the Carrier appropriately paid for fair and reasonable for this service according to the fee guidelines. No additional reimbursement is warranted."

Principal Documentation:

1. DWC 60 Package

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
2/20/2006	L8681	$865.16 X 125% = $1,081.45. This amount minus previously paid of $643.72 = $437.73	$437.73	$437.73
			Total Due:	$437.73

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. This request for medical fee dispute resolution was received by the Division on January 23, 2007.

2. Division rule at 28 TAC §134.202, titled *Medical Fee Guideline*, effective August 1, 2003, sets out the reimbursement for medical treatment and services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 12/9/2006

   - 45, W1-Charges exceed your contracted/legislated fee arrangement. Workers Compensation state fee schedule adjustment note to employer: The fees set forth herein may include both Concentra's fees to the carrier/TPA for Concentra's services as well as fees by the carrier/TPA related to Concentra's services. Focus/Beech Street.

Issues

1. Is there a contractual agreement between the parties?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The Respondent raised the issue of a contractual arrangement between the parties; however, a review of the submitted EOBs does not support a PPO reduction was taken. On February 26, 2007, the requestor's representative Mansel Herman submitted an email to the Division and stated that the requestor did not participate in any PPO network. The respondent did not submit a copy of a contractual agreement to support this EOB denial to the Division; therefore, the disputed services will be reviewed in accordance with Division rule at 28 TAC §134.202.
2. Division rule at 28 TAC §134.202(b) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program methodologies, models, and values or weight including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section."

   Division rule at 28 TAC §134.202(c)(2) states "for Healthcare Common Procedure Coding System (HCPCS) Level II codes, A, E,J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; (B) if the code has no published Medicare rate, 125% of the published Texas Medicaid Fee Schedule Durable Medical Equipment/Medical Supplies Report J, for HCPCS; or (C) if neither paragraph (2)(A) nor (2)(B) of this section apply, then as calculated according to paragraph (6) of this subsection."

   HCPCs code L8681 is described as "Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only." Per DMEPOS, HCPCS code L8681 has a fee of $865.16.

   Per Division rule at 28 TAC §134.202(c)(2), the DMEPOS fee of $865.16 multiplied by 125% = $1,081.45. This amount minus previously paid of $643.72 = $437.73. This amount is recommended for reimbursement.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports the reimbursement amount sought by the requestor. For the reasons stated above, the division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $437.73.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to $437.73 additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of $437.73 plus applicable accrued interest per Division rule at 28 Tex. Admin. Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature	Medical Fee Dispute Resolution Officer	**7/23/2010** Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.